

**CLINICAL SOCIAL WORKER
EXPERIENCE VERIFICATION**

1800 37A-201 (REV. 12/05)

*The supervisor must complete this form. Use a separate form for each person verifying hours of supervised experience in a clinical setting for licensure as a clinical social worker and for each employment setting. **Make certain that the form is complete and correct prior to signing. Any change should be initialed by the supervisor and is subject to verification. Experience verification forms are to be submitted by the applicant with his or her application for licensure.***

APPLICANT NAME: _____

I. SUPERVISOR: (Please type or print clearly in ink.)

1. SUPERVISOR NAME: Last First Middle

2. ADDRESS: Number and Street

City State Zip Code

3. BUSINESS TELEPHONE:

4. NAME OF APPLICANT'S EMPLOYER:

5. ADDRESS: Number and Street

City State Zip Code

6. BUSINESS TELEPHONE:

7. Experience was gained in a setting that lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy? Yes ☐ No ☐8. Experience was gained in a setting that provided oversight to ensure that the associate's work meets the experience and supervision requirements and is within the scope of practice for the profession? Yes ☐ No ☐9. As the supervisor I provided supervision on a voluntary basis? Yes ☐ No ☐
If yes, attach the original written agreement between you and the applicant's employer as required by Business and Professions Code Sections 4996.20(d) 4996.21(e) and 4996.23(m).

10. Dates the experience is being claimed: From Mo Day Yr To Mo Day Yr

11. Total number of supervised weeks worked: (minimum 104)

a. Total number of individual supervision hours: a. _____

b. Total number of group supervision hours: b. _____

12. Total number of hours worked per week (maximum hours 40): _____

13. Total number of hours in clinical psychosocial diagnosis, assessment, including individual or group psychotherapy/counseling: (minimum hours required 2,000) A. _____

Total number of face-to-face individual or group psychotherapy/counseling: A1. _____

(minimum hours required 750)

Total number of hours in client-centered advocacy, consultation, evaluation, and research: (maximum hours 1,200) B _____

Total number of hours of experience: (minimum hours required 3,200) A + B = C C. _____

14. One hour of face-to-face individual or two hours of face-to-face group supervision was given for every week in which more than 10 hours of face-to-face psychotherapy was performed? Yes ☐ No ☐

15. SUPERVISOR: Type of License License Number State of License Date Originally Licensed

If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision?

Yes ☐ No ☐ Date Board Certified: _____***I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.***

Date

Signature